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~~04/94~~ ~~b. The hospital must file a cash position statement which is based upon current assets (including all unrestricted investments), current liabilities and other data for a date which is less than 60 days old. Any liabilities payable to owners or related parties must not be reported as current liabilities on the cash position statement.~~

~~07/96~~ ~~c. The hospital must submit a copy of its last two~~three ~~financial statements audited by an external, independent certified public accountant. If the hospital is part of a group of entities which are related by common ownership and/or control, a consolidated financial statement audited by an external, independent certified public account~~accountant ~~is also required. If consolidated financial statements are not available, then the individual audited financial statements from each of the related entities may be submitted separately. The Department will merge the information. A hospital that qualifies for financial relief under 4.d.ii. below, must submit copies of all relevant its last three or five audited financial statements., depending upon the qualification option chosen.~~

~~04/94~~ ~~4. Appeal Process. In no event shall financial relief be awarded, unless the hospital demonstrates to the satisfaction of the Director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality. In making such demonstration the hospital must meet all of the following criteria:~~

~~04/94~~ ~~a. The current Medicaid prospective payment rate jeopardizes the long term financial viability of the hospital. In appropriate cases, financial jeopardy may be shown to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss. In appropriate cases, financial jeopardy may be shown to exist if the hospital is incurring a marginal gain but can demonstrate that it has unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long term financial viability.~~

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~~07/96~~ ~~b. The population served by the hospital seeking financial relief has no reasonable access to other inpatient hospitals.~~

~~07/96~~ ~~c. The ratio of current assets to current liabilities reflected on the cash position financial statement described in Section 3.b. above must reflect a ratio of current assets to current liabilities that is less than, or equal to, 1.0. Hospitals whose Medicaid inpatient utilization rate as defined in C.8.c. of Chapter VI, is greater than 50% and it's average length of stay during state fiscal year 1994 was less than 20 days, However, when determining such ratios a hospital may exclude Medicaid accounts receivables from this calculation and define funded depreciation as a restricted fund under 6.eg. below., if:~~

~~i. the hospital's Medicaid inpatient utilization rate, as defined in C.8.c. of Chapter VI, is greater than 50 percent, and it is not a hospital as described in C.1, C.3.a., or C.4 of Chapter II; or~~

~~ii. the hospital qualified for Critical Hospital Adjustment Payments (CHAP) under Chapter XV in State fiscal year 1996, it has a Medicaid utilization rate, as defined in C.8.c. of Chapter VI, that is greater than 40 percent, it has a combined Medicaid/Medicare utilization rate, as defined in 6.d. below, that is greater than 70 percent, and it has an uncompensated care percent, as described in 6.f. below, that is greater than 4 percent.~~

~~07/96~~ ~~d. The financial statements described in Section 3.c. above must reflect: a net loss in each of the three periods, however:~~

~~i. a net loss in each of the two periods if the hospital's Medicaid inpatient utilization rate, as defined in C.8.c. of Chapter VI is less than 50 percent, orfor a hospital whose Medicaid inpatient utilization rate, as defined in C.8.c. of Chapter VI, is greater than 50 percent, is not a hospital as described in C.1., C.3.a., or C.4. of Chapter II, or A.1.a.i. of Chapter XVI, must reflect a net loss in two out of the last four periods or a net loss in three out of the last six periods. Hospitals qualifying under this J.4.d.i. may exclude 2.5 percent of their net operating revenue and payments made for hardship relief granted pursuant to Section J of Chapter IX during State fiscal year 1995 and 1996 from this calculation.~~

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~~Hospitals whose fiscal year ends on or no later than six months prior to June 30, 1996, may submit a preliminary financial statement for the hospital's fiscal year ending June 30, 1996, or a period no less than six months between the end of its fiscal year and June 30, 1996. This preliminary financial statement must utilize generally accepted accounting principals and be accompanied with an attestation, signed by the hospital's Chief Executive Officer and Chief Financial Officer, as to the accuracy and validity of such statement. In addition, hospitals owned by a Federally Qualified Health Center (FQHC) may exclude federal Section 330 grant revenue from this calculation; or~~

~~ii for hospitals that qualified for Critical Hospital Adjustment Payments under Chapter XV in State fiscal year 1996, whose Medicaid utilization rate, as described in C.8.e. of Chapter VI, was greater than 40 percent, whose combined Medicaid/Medicare utilization rate, as described in 6.d. below, was greater than 70 percent, and whose uncompensated care percent, as described in 6.f. below, was greater than four percent, must reflect a net loss in two out of the last four periods or a net loss in three out of the last six periods. Hospitals qualifying under this J.4.d.ii. may, in addition to the deductions and the ability to submit preliminary financial statements, as identified under J.4.d.i. above, deduct revenue derived from a FQHC clinic that is physically located on the immediate hospital campus.~~

~~ii. a net loss in two out of the last three periods (hospitals owned by a Federally Qualified Health Center (FQHC) may exclude federal section 330 grant revenue from this calculation), or reflect a net loss in three out of the last five periods with an aggregate loss over the five year period, if the hospital's Medicaid inpatient utilization rate, as defined in C.8.e. of Chapter VI, is greater than 50 percent and its average length of stay during State fiscal year 1994 was less than 20 days.~~

~~07/96~~ ~~e. The most recent financial statement as described in Section 3.c. above must reflect a ratio of current assets to current liabilities of less than 1.3, or equal to, 1.4. Hospitals whose Medicaid inpatient utilization rate, as defined in C.8.e. of Chapter VI, is greater than 50 percent and it's average length of stay during fiscal year 1994 was less than~~

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~~20 days, may exclude Medicaid accounts receivable from this calculation and define funded depreciation as a restricted fund under 6.e. below.However, when determining such ratios, a hospital may exclude Medicaid accounts receivable from this calculation and define funded depreciation as a restricted fund under 6.g. below, if:~~

~~i. the hospital's Medicaid inpatient utilization rate, as defined in C.8.e. of Chapter VI, is greater than 50 percent, and it is not a hospital as described in C.1., C.3.a., or C.4. of Chapter II, or A.1.a.ii. of Chapter XVI; or~~

~~ii. the hospital qualified for Critical Hospital Adjustment (CHAP) under Chapter XV in State fiscal year 1996, and it has a Medicaid utilization rate, as defined in C.8.c. of Chapter VI, that is greater than 40 percent, and it has a combined Medicaid/Medicare utilization rate, as defined in 6.d. below, that is greater than 70 percent, and it has an uncompensated care percent, as described in 6.f. below, that is greater than four percent.~~

~~04/94~~ ~~5. Financial relief. If the hospital demonstrates adequate financial jeopardy, the Department will determine the amount of the financial relief to be granted. The amount of the financial relief will be dependent upon the individual hospital's needs.~~

~~04/94~~ ~~6. Definitions. For purposes of this Section, unless the context requires otherwise:~~

~~04/94~~ ~~a. "Current assets" must follow Generally Accepted Accounting Principles, except for this purpose all unrestricted investments must be included as current assets.~~

~~04/94~~ ~~b. "Current liabilities" must follow Generally Accepted Accounting Principles, except for this purpose any liabilities due to entities related by ownership or control must not be included as current liabilities.~~

~~04/94~~ ~~c. "Marginal loss" is the amount by which total variable costs for each patient day exceeds the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60 percent of total inpatient operating costs and fixed costs at 40 percent of total inpatient operating costs; however, the Director may accept a different ratio of fixed and variable operating costs if a hospital is able to~~

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~~demonstrate that a different ratio is appropriate for its particular institution.~~

~~==07/96~~ ~~d.~~ ~~"Medicaid/Medicare Utilization Rate" means the Medicaid inpatient utilization rate as described in C.8.c. of Chapter VI, plus the Medicare inpatient utilization rate, a calculation of which the numerator is the number of hospital Medicare inpatient days provided in the base fiscal year~~

~~described in C.8.a. of Chapter VI as reported on the Medicare cost report (HCFA 2552) and the denominator of which is the total number of hospital inpatient days in the same period as reported on the Medicare cost report (HCFA 2552).~~

~~==07/96~~ ~~dc.~~ ~~"Ratio of current assets to current liabilities" means current assets divided by current liabilites, as defined above.~~

~~==07/96~~ ~~f.~~ ~~"Uncompensated Care Utilization Rate" means a fraction of which the numerator is the hospital's uncompensated care charges provided in a given twelve month period, as described in D.1.b.iv. of Chapter VI, and the denominator of which is the hospital's total charges, as described in D.1.b.ii. of Chapter VI, in that same base year, as described in D.1.b.iii. of Chapter VI. The term "uncompensated care charges" shall include charges for services reimburseable by the Department under the Transitional Assistance Program and the Family and Children Assistance Program, formerly known as General Assistance (Article VI).~~

~~==07/96~~ ~~eg.~~ ~~"Unrestricted investments" means funds which have not been restricted by the donors for use only for some purpose other than hospital operations. Also, investments which have been legally restricted against use for hospital operations, such as loan collateral, will be considered to be restricted. Funds restricted by the hospital's board of directors will be considered as unrestricted funds for the purpose of this analysis unless otherwise allowed for under the provisons noted in 4.c., 4.d.ii., or 4.c. above.~~

~~==07/96~~ ~~7.~~ ~~Nothing in these provisions shall preclude the Director of the Department of Public Aid from making mid year adjustments to the hospital hardship payments made under this Section.~~

~~==07/96~~ ~~8.~~ ~~This Section shall remain in effect until June 30, 1997.~~

==07/97 ~~K~~J. Critical Hospital Adjustment Payment (CHAP) Reviews

==07/97 1. The Department shall make CHAP payments ~~CHAPs~~ in accordance with Chapter XV.

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Hospitals shall be notified in writing the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for CHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the CHAP. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

==07/95 2. CHAP determination reviews shall be limited to the following:

==07/95 a. Federally Designated Health Professional Shortage Areas (HPSAs). Illinois hospitals located in federally designated HPSAs shall be identified in accordance with 42 CFR 5, and Section A.3.b. and B.3. of Chapter XV based upon the methodologies utilized by, and the most current information available to the Department from the Department of Health and Human Services as of the last day of June preceding the CHAP rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of the last day of June preceding the CHAP rate period.

==07/95 b. Trauma level designation. Trauma level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.

==07/95 c. Accreditation of Rehabilitation Facilities. Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating that the information supplied to and utilized by the Department was incorrect.

==07/95 d. Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923

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of the Social Security Act and as defined in Section C.8.e. of Chapter VI. Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

==07/95 e. Perinatal level designation. Perinatal level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.

f. Disproportionate share eligibility. Disproportionate share eligibility shall be determined pursuant to Section C. of Chapter VI. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.

==07/95 g. Occupancy ratio. The occupancy ratio shall be obtained from the Illinois Department of Public Health's published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois" as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.

==07/95 h. Graduate Medical Education Programs. Graduate Medical Education program shall be obtained from the most recently published report of the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the above, substantiating that the information supplied to and utilized by the Department was incorrect.

==07/97 K. Supplemental Critical Hospital Adjustment Payment (SCHAP) Reviews.

The Department shall make SCHAP payments in accordance with Sect.I of Chapter XV. Hospitals shall be notified in writing of the results of the SCHAP determination and calculation, and shall have the right to appeal the SCHAP calculation or their ineligibility for SCHAP payments if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received

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within 30 days after the date of the Department's notice to the hospital of its qualification for SCHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for SCHAP payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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X. Transplant Care

09/91 A. Hospital services rendered for transplant procedures (with the exception of kidney and cornea transplants which are reimbursed in accordance with Chapters IV. and VII., Chapter VIII., Chapter XIII., or Chapter XIV., as applicable) under this Section are exempt from the provisions of Chapters IV., VII., VIII., XIII., and XIV., of this State Plan. Hospital reimbursement for transplants covered within this Section is an all-inclusive rate for the admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for the number of days listed below for specific types of transplants:

1. Three days of preoperative inpatient work-up; and

10/94 2. A maximum 30 consecutive days of postoperative inpatient care for heart, heart/lung, lung (single or double), pancreas, or kidney/pancreas transplant; or

3. 40 consecutive days of inpatient care for liver transplant; or

4. 50 consecutive days for inpatient care for bone marrow transplant; or

5. For other types of transplants covered when a hospital has been certified by the Department, the number of consecutive days of inpatient care specified within the transplant certification process.

07/95 6. Applicable disproportionate share payment adjustments shall be made in accordance with Section C.7. of Chapter VI. Applicable outlier adjustments shall be made in accordance with Section F. of Chapter VIII. Applicable specific inpatient payment adjustments shall be made in accordance with Chapter VI.

09/91 B. The Department will cover organ transplants identified as covered service and provided by certified organ transplant centers; meets the Department's certification requirements including, but not limited to, completion and submission of the required application, patient selection criteria and detailed status reports for all transplants.

The certified transplant center will be determining the medical necessity and appropriateness of transplant procedures but must notify the Department prior to performance of the transplant procedure.

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XI. Hospital Residing Long Term Care

10/93 A. Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is enrolled with the Department to provide hospital residing long term care:

1. A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or

2. A special unit or separate facility administratively associated with the hospital and licensed as a long term care facility.

B. There are three categories of service for hospital residing long term care. These categories are as follows:

1. Skilled Care - Hospital Residing (category of service 37). Reimbursement is available for hospitals providing hospital residing long term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

a. The hospital must document its attempt to place the patient in at least five appropriate facilities.

b. Documentation (form DPA 3127) must be attached to the appropriate claim form and submitted to the Department.

c. Reimbursement is limited to services provided after the minimum number of contacts have been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement will be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.